



Tennessee Department of Health

Notifiable Disease Report

All Tennessee physicians, hospitals, laboratories and other health care providers are required by law (T.C.A. 68-10-101) to report the occurrence of the diseases and conditions listed on the back of this report to their county health department. Both laboratory-confirmed and clinical diagnoses are reportable within the time interval specified. (Disease codes listed on the back of this report.)

Disease/Code	Onset date	Patient Information / Physician / Hospital Information	DOB	Sex	Race and Ethnicity
	___/___/___	Patient Name:	___/___/___		
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Adm: ___/___/___ Disch: ___/___/___ Died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown STD treatment: _____ Date of treatment: _____		Address: _____ City: _____ County: _____ State: _____ Zip code: _____ Phone: () _____ Physician/Hospital: _____ Phone: () _____	<u>Laboratory information:</u> Test: _____ Collection Date: ___/___/___ Specimen type: _____ Result: _____		
Disease/Code	Onset date	Patient Information / Physician / Hospital Information	DOB	Sex	Race and Ethnicity
	___/___/___	Patient Name:	___/___/___		
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Adm: ___/___/___ Disch: ___/___/___ Died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown STD treatment: _____ Date of treatment: _____		Address: _____ City: _____ County: _____ State: _____ Zip code: _____ Phone: () _____ Physician/Hospital: _____ Phone: () _____	<u>Laboratory information:</u> Test: _____ Collection Date: ___/___/___ Specimen type: _____ Result: _____		
Disease/Code	Onset date	Patient Information / Physician / Hospital Information	DOB	Sex	Race and Ethnicity
	___/___/___	Patient Name:	___/___/___		
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Adm: ___/___/___ Disch: ___/___/___ Died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown STD treatment: _____ Date of treatment: _____		Address: _____ City: _____ County: _____ State: _____ Zip code: _____ Phone: () _____ Physician/Hospital: _____ Phone: () _____	<u>Laboratory information:</u> Test: _____ Collection Date: ___/___/___ Specimen type: _____ Result: _____		

Date of Report: ___/___/___

Person Reporting/Title: _____

Phone: () _____

